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Lifeguard Pharmacy - A feasibility trial of a novel pharmacy-based intervention for people experiencing domestic abuse and/or suicidal ideation.

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Abstract

Background

Domestic abuse (DA) and suicidal ideation (SI) are highly prevalent in the United Kingdom, often co-occurring. Numerous practical and psychosocial barriers inhibit help-seeking. This study explored whether community pharmacy could offer an accessible setting for a DA and SI response service.

Methods

12 pharmacies were recruited from one pharmacy organisation, randomised into 8 intervention pharmacies and 4 controls. 37 pharmacy staff were recruited as participants and trained to deliver the Lifeguard Pharmacy intervention, which involved providing a consultation and structured referral or signposting to customers identified as experiencing DA and/or SI. Participants' learning from the training was evaluated using the validated CPD reaction questionnaire, analysed using a Paired T-Test The intervention ran from January to July 2023 and was accompanied by a nested process evaluation consisting of staff focus groups and a multi-stakeholder final evaluation workshop with a mix of lay, pharmacy staff and representatives from referral organisations. Data was collected on number and category of client contacts from intervention and control pharmacies; descriptive analyses were performed.

Results

After intervention training, pharmacy staff showed statistically significant improvements in their levels of perceived ability, ease and confidence in responding to and referring people in need of help for DA and SI with increased confidence in the ability of other pharmacy staff to support DA and SI. Staff responded to 24 cases in intervention pharmacies: 8 for suicidal ideation, 9 for domestic abuse and 7 for both domestic abuse and suicidal ideation. Of these, 22 were staff-initiated and two were patient-initiated. Two cases (1 x SI and 1 x DA) were identified in control pharmacies. Staff participants had a positive perception of the service and its impact on them and their clients. The multi-stakeholder workshop findings confirmed the feasibility of a staff-initiated response service for both DA and SI in a community pharmacy setting.

Conclusions

It is feasible to implement a staff-initiated response service for DA and/or SI in selected pharmacies. The combination of staff training, consultation guide, referral tool and client support resources and organisational support empowered staff to proactively identify people experiencing DA and/or SI.

Background

Domestic abuse (DA) and suicidal ideation (SI) are major public health issues in the UK. In year ending March 2022, an estimated 1.7 million women and 699,000 men in England and Wales experienced DA, defined as physical, emotional/psychological, sexual or economic abuse, violent or threatening and/or coercive and controlling behaviour perpetrated by a current or former partner or a family member (1, 2). DA adversely affects a range of health outcomes (3). The estimated annual cost of DA in the UK is £66 billion (4). In 2021, 5,583 suicides were registered in England and Wales, three-quarters of which were in men (5). For both men and women, suicides are most common amongst 40 to 50-year-olds (5, 6). Each suicide has an estimated economic cost of £1.67 million (7).

Formative public engagement conducted by JS (author) on barriers to help-seeking behaviour for domestic abuse found high demand for a more informal, drop-in service that would facilitate people's first step to seeking help (8). Community pharmacies are ideally placed to provide such a service. They provide NHS services to around 1.6 million people a day. Throughout England, over 89% of people have a community pharmacy within a 20-minute walk from home. Within areas of highest deprivation this increases to almost 100% (9). They are highly accessible by virtue of being a walk-in, no-appointment service with long opening hours (10). Furthermore, community pharmacies are encouraged to embrace roles as health and wellbeing hubs beyond traditional medicine supply roles (11).

The community pharmacy contractual framework in the UK includes the Pharmacy Quality Scheme (PQS), which now requires pharmacy staff to receive safeguarding and suicide prevention training. As yet, there is no formal suicide prevention service in UK pharmacies. Community pharmacy responses to DA have progressed further. During the 2020–2021 Covid-19 pandemic, the "Safer Spaces" and "Ask for ANI" initiatives (12, 13) were rapidly implemented in UK pharmacies. Using the code word "ANI", victims of D can access support from participating pharmacies to call the police or the National Domestic Abuse Helpline. However, the service has a limited evidence-base, is not routinely embedded in local services and does not provide accredited staff training, resources or support. Other studies in the UK (14) and the USA (15) have found that pharmacy staff are willing to support DA victims but require more training and information about onward referral pathways (14).

Therefore, this study examines the feasibility of community pharmacy-based response service for people experiencing DA and/or SI. This study is innovative in addressing both DA and SI. The rationale for this is three-fold. Firstly, systematic review evidence (16) and re-analysis of the 2013 Adult Psychiatric Morbidity Survey in England (17) indicate that DA and suicidality often co-occur. Secondly, both issues are difficult to talk about and share a psychological burden of stigma and shame (18, 19). Thirdly, early intervention is critical to ensure safety, improve health, and provide access to specialist support. However, enabling early intervention continues to be a challenge (20–22).

Methods

The design, scope and resources for the response-service were co-developed with lived experience and professional stakeholders prior to the feasibility testing phase (23). The service was named “Lifeguard Pharmacy” with the strapline of “Bringing Hope to Life” and accompanying logo of a green and white life-ring (see supplementary material). This feasibility trial aimed to deliver the service as a complex intervention in a purposive sample of community pharmacies and collect feasibility data on implementation, intervention usage, acceptability and intervention fidelity.

The objectives were to:

1. To evaluate the effectiveness of the staff training for the intervention
2. To evaluate the implementation and usage of the intervention
3. To evaluate pharmacy staff acceptability towards the intervention
4. To evaluate intervention fidelity
5. To identify and evaluate the attitudes of lay people, pharmacy staff and relevant professionals towards the feasibility and future viability of the intervention

Twelve pharmacies were recruited from one pharmacy organisation and randomised using computer generated random number allocation by Lincoln Clinical Trials Unit into eight intervention pharmacies and four controls based on stratification by pharmacy type and setting (matrix of urban/small, urban/large, rural/small and rural/large). There were therefore two intervention pharmacies and one control pharmacy per stratification category. It was considered that these numbers would provide reliable feasibility data given the uniformity of pharmacy systems. Inclusion criteria were that the pharmacy must have approval from the superintendent pharmacist to participate and must have a private, accessible consultation room and a functioning working relationship with their local GP practice. Exclusion criteria were insufficient general staffing to meet their opening times obligations, lack of an accessible and private consultation room, non-functioning working relationship with local GP practice or inability to recruit a minimum of three staff participants in that pharmacy. 37 pharmacy staff were then recruited as participants and consented to being trained, delivering the intervention as a service and participating in the nested process evaluation (see Table 1 for methods overview). Inclusion criteria for staff were that they had line management approval to participate, were 18 years old or over and in a patient-facing role in the pharmacy. The service ran for 6 months from January to July 2023, during which time client data and evaluation data were collected. This consisted of the number of clients assisted per category of issue as the primary outcome, with secondary outcomes of: organisations referred to, basic client demographics, reasons for choosing to access the service and length of time of the consultation (see supplementary material for further details). Client inclusion criteria were that they were 18 years old or over and experiencing some level of suicidal ideation or domestic abuse. The study was conducted in the East Midlands region of England.

NHS research ethics and governance approval was granted on 12.12.22 for IRAS Project ID: 309018 / Sponsor Ref: 112201.

Table 1
Overview of Study Methods

	Intervention	
	Phase	Overview
A.	Recruitment of pharmacies	(i) **Organisational consent** - superintendent pharmacist gave written consent to approach pharmacies. The pharmacy organisation was given a token of appreciation payment. Pharmacies were recruited from the same pharmacy organisation. They met the criteria of giving a balance of large commercial / small and urban and rural locations over a range of socioeconomic areas (Index of Multiple Deprivation Decile). (ii) **Purposive sampling** – selection of three pharmacies per category of rural/small pharmacy, rural/large store, urban/small pharmacy, urban/large store, with a spread across different socio-economic areas (based on deprivation index from Office for National Statistics). (iii) **Randomisation** - with stratification by pharmacy type to give 2 pharmacies from each of the four categories as interventions (total of 8), and 1 pharmacy from each of the four categories as a control (total of 4).
B.	Recruitment of staff in pharmacies	(i) **Approach** - all staff that met inclusion criteria given participant information sheet, consent form and explanation of the study (by AMB by phone and follow-on e-mail exchange). (ii) **Recruitment** - of a minimum of 3 members of staff per intervention pharmacies and 1 per control pharmacy (by AMB). Staff participants in intervention pharmacies consented to research activities: C, D,E,G,H. Support provided (F).
C.	Training staff in intervention pharmacies	(i) **Pre-requisite** – completion of the normal training requirement for Suicide Prevention and Safeguarding that are provided for all staff by the pharmacy organisation to fulfil the criteria of the U.K. Pharmacy Quality Scheme (PQS) and the organisation's own domestic abuse e-learning module that all staff are required to complete. (24) (ii) **Lifeguard training** - attendance at 6 hours of live facilitator-led training, either as an in-person training event at the University of Lincoln on a Saturday, or 3 x 2-hour evening online events via Microsoft Teams. The training was led by JS, RB and AMB with input from the psychotherapist who was providing emotional support for staff and a person with lived experience. Staff were invited to complete 2 x CPD reaction questionnaires (25), which is a validated tool (see supplementary material). They completed one for SI and one for DA both before and after their training to evaluate the impact of the training. Changes in responses to the before and after CPD reaction questionnaires (one set for SA and one set for DA) were analysed using SPSS software for paired t-tests. (iii) **Induction** - engagement in 2 x mock consultations (one for SI and one for DA) in their own pharmacy with a member of the research team. (iv) **Accreditation** - After successful completion of all training components (i, ii & iii) staff were awarded a certificate of completion and "Lifeguard" badge.
D.	Implementation of the intervention	(i) **Organisational induction** - (JS) led an induction meeting with senior staff in the organisation and staff rota manager. The data protection, marketing department, safeguarding and training leads were involved in the launch of the intervention. (ii) **Control pharmacies** – in-person induction visits by AMB, delivered usual care (which could include consultations based on the normal training requirements), kept simple log of number of requests for DA and/or SI. (iii) **Intervention pharmacies**: • supplied with the intervention resources as listed and study website made available to market the service to potential clients (see supplementary material). • Staff were available to deliver the service as required (either client- or staff-initiated). • Staff required to consent client participants and collect data **(as further details in supplementary material).**
E.	Intervention monitoring and data collection	(i) **Intervention pharmacy monitoring** – monthly site visits by AMB to support staff, collect data, check the fidelity of the intervention, and collect feedback from staff about their experiences of delivering the intervention. (5 x visits per pharmacy) (ii) **Control pharmacy monitoring** – monthly phone calls by AMB to support staff and collect data. (iii) **Pharmacy organisation** – The pharmacy organisation provided the number of service items conducted by all 12 pharmacies (intervention and control) each month during the 6-month intervention and for the same months the year before. This data is publicly available and is not subject to data storage restrictions. A pharmacy specification checklist had been created in the co-development phase and was part of the Pharmacy Operating Manual (see supplementary material). Fidelity against these items was checked at the monthly visits (by AMB) in addition to checking on the staff's own wellbeing, their experience of delivering the intervention and collecting any feedback.
F.	Staff support	**Optional support for intervention staff** - confidential mentoring sessions with a psychotherapist in case of emotional distress (30 mins per participant per month), pairing for peer support with another staff member, access to research team for advice.
	Nested Process Evaluation	
G.	Staff focus groups	**Evaluation of staff's experience** - all staff participants in intervention pharmacies were invited to take part in either an in-person or online focus group to evaluate staff's experience of delivering the intervention.
H.	Feasibility workshop	**Evaluation of feasibility** – summary multi-stakeholder feasibility workshop to review the Lifeguard Pharmacy intervention and make recommendations for practice and future research. Participants were a selection of staff from each intervention pharmacy, the public and patient engagement panel, representatives from referral organisations and the entire research team. All participants had already been connected to the project and received participant information and consent forms prior to the event. Pharmacy staff participants received a £75 fee for participating as a token of appreciation. PPI panel members received their usual fee for contributing.

Delivery of the intervention (objectives 1,2&4)

The intervention involved training community pharmacy staff participants ("Lifeguards") to respond to any clients experiencing either suicidal ideation and/or domestic abuse. Consultations could be a) client initiated, through handing the cue card either physically or on their phone, or by asking directly; b) staff initiated, due to recognition of prompts for help. The flow of clients into and out of the consultation room was specified by a "Client Flow Chart". A Consultation Guide was used which contained key exploratory questions, followed by shared decision making around plans for signposting or referral, based on categories of severity and urgency as follows: level 1 -"assistance required", level 2 - "action required" or level 3- "alert emergency service", and finally safety-netting by supplying the client with a relevant SI and or DA support card and explanation. Control pharmacies delivered usual care which was to manage any instances of SI or DA through their usual safeguarding policy.

Intervention data collection and analysis - The "Lifeguards" (staff participants) were required to explain the study to clients and seek their informed consent. There were four sections of data, each for different purposes, with different consent and storage considerations (see further details in supplementary material). The control pharmacies were required to keep a log of the number of encounters they had with customers/patients that involved SI and/or DA. These data were entered on to a database created using Castor EDC (26).

Each pharmacy was provided with two lockable storage cabinets. If clients did not consent for any data collection and/or they did not meet the inclusion criteria for the service, then the pharmacy staff were advised to follow their usual safeguarding procedures. Lifeguards could use their judgement in situations of distress and crisis and choose not to ask the client the set of questions on access and demographics (see supplementary material). The research team visited each intervention pharmacy monthly to collect data and monitor fidelity.

Nested Process Evaluation (objectives 3 & 5)

Staff Participant Qualitative Focus Groups – A topic guide was developed to explore views on the acceptability of the service based on the Theoretical Framework for Acceptability of Healthcare Interventions (see supplementary material) (27). An in-person focus group was held at the University of Lincoln in April 2023 and was attended by four participants. Two online focus groups were hosted on Microsoft Teams in May and April 2023, with a total of 23 participants. Because of the size of the online groups, each group was divided into two breakout rooms after an introductory overview, each with two facilitators. The groups were led by combinations of JS, RB, AB and DJ. Participants were encouraged to raise additional issues which were pertinent for them, including any negative feedback, or points which contradicted other participants' views.

All focus groups were audio-recorded with participants' consent and subsequently transcribed, anonymised and coded using QSR NVivo 11. One transcript was independently coded by two researchers (RB and AB), to develop a coding tree. Further coding nodes were added as coding progressed. Framework Analysis was used because of its capacity to accommodate the numerous deductive codes from the feasibility objectives, whilst retaining the flexibility to add inductively identified codes (28).

Multi-Stakeholder Feasibility workshop - A topic guide and discussion sheet was developed for the mixed-methods (qualitative and quantitative) workshop using the Consolidated Framework for Implementation Research (29). The workshop aimed to assess all data sources and seek an assessment of overall feasibility from the perspectives of lay, pharmacy and wider professional stakeholders. The discussion sheets (see supplementary material) asked key questions about participants' views on the scope, setting, means of access and record keeping aspects of the intervention. Presentations were given on the study findings, synthesising the feasibility trial findings. Six breakout groups were then formed, each led by a researcher. Each participant was asked to answer the questions on the discussion sheet. Participants were encouraged to state their own views and not feel pressurised to agree with others. Quantitative response data were analysed using descriptive statistics and free-text comments were analysed qualitatively using thematic coding via QSR Nvivo 11.

Results

Intervention

8 intervention and 4 control pharmacies were recruited using with stratification for rural or urban setting and small or large pharmacy (based on footfall), across a range of Indices of Multiple Deprivation. However, two of the pharmacies that were originally randomised to be intervention pharmacies were moved to be controls, due to failure to meet the required levels of staffing. Subsequently, two pharmacies in the control group agreed to become intervention pharmacies. Table 2 shows the final allocation of pharmacies.

Table 2
Intervention and Control Pharmacy Characteristics

Pharmacy ID Code	Sampling Category	Intervention or Control	Index of Multiple Deprivation in Decile	Number of staff recruited per pharmacy
A	Large Rural	Intervention	6	3
C	Large Urban	Intervention	4	6
D	Large Urban	Intervention	2	4
E	Small Rural	Intervention	3	4
F	Small Rural	Intervention	10	6
H	Small Urban	Intervention	10	3
I	Small Urban	Intervention	3	6
J	Large Rural	Intervention	3	5
W	Large Rural	Control	10	1
X	Large Urban	Control	6	1
B	Large Rural	Control	8	1
G	Small Urban	Control	1	1
				Total 41

45 patient-facing staff were initially recruited from the intervention pharmacies, but 8 withdrew before the start of the intervention. 6 of these 8 failed to attend any training sessions, 1 completed part of the training but withdrew due to illness and the other completed the training sessions but not the mock consultations. 37 staff successfully completed the training and continued with the study. These numbers comprised 11 pharmacists, 2 trainee pharmacists, 3 pharmacy technicians, 17 dispensers and 3 counter assistants (1 participant did not provide details of role title on the questionnaire). Each staff participant was given a unique study ID code. There were 4 staff participants in the controls.

7 out of the 8 intervention pharmacies remained in the study for the 6 months duration of the intervention period. One pharmacy was withdrawn from the study in month 5, because the number of trained “Lifeguard” staff had fallen below the minimum to ensure adequate coverage (from 4 participants down to 2 participants). The total number of intervention staff participants at the end of the intervention was 33 (73.3% of the original number recruited) (see Fig. 1 for flowchart of staff participant engagement).

Impact of Staff Training - All 37 staff participants that attended the training completed the first set of two CPD reaction questionnaires (25) before the training and 56.8% (21 out of 37) completed the second domestic abuse questionnaire and 62.2% (23 out of 37) completed the second suicidal ideation questionnaire after the training. See Table 3 for questionnaire results.

Table 3
Participant responses to CPD Reaction Questionnaires for Domestic Abuse and Suicidal Ideation

	CPD Reaction Questionnaire Questions for Domestic Abuse / Suicidal Ideation		Mean score before	Mean score after	t-test score	SD	Paired t-test 2-sided p value
Q1	I intend to effectively respond and refer (where appropriate) people in danger of domestic abuse (DA)/ suicidal ideation (SI):	DA	6.6	6.5	0.357	1.221	0.724
	1 = strongly disagree, 7 = strongly agree	SI	6.2	6.2	0.09	2.306	0.929
Q2	To the best of my knowledge, the percentage of my colleagues who effectively respond and refer (where appropriate) people in danger of domestic abuse (DA) / suicidal ideation (SI) is:	DA	3.2	4	-2.795	1.327	**0.011**
	0-20%, 21-40%, 41-60%, 61-80%, 81-100%	SI	3.1	3.7	-2.03	1.438	0.055
Q3	I am confident that I could effectively respond and refer (where appropriate) people in danger of domestic abuse if I wanted to:	DA	4.9	6	-2.643	2.064	**0.016**
	1 = strongly disagree, 7 = strongly agree	SI	4.9	6.1	-2.921	1.999	**0.008**
Q4	Effectively responding and referring (where appropriate) people in danger of domestic abuse is the ethical thing to do:	DA	6.3	6.5	-0.429	1.526	0.673
	1 = strongly disagree, 7 = strongly agree	SI	6.4	6.4	0	1.931	1.00
Q5	For me, effectively responding and referring (where appropriate) people in danger of domestic abuse would be:	DA	3.9	5	-4.6	1.091	**0**
	1 = Extremely difficult, 7 = Extremely easy	SI	3.9	5	-3.861	1.296	**0.001**
Q6	Now think about a co-worker whom you respect as a professional. In your opinion, does he/she effectively respond and refer (where appropriate) people in danger of domestic abuse?	DA	5.1	6	-2.795	1.327	**0.011**
	1 = Never, 7 = Always	SI	5	5.5	-1.358	1.996	0.188
Q7	I plan to effectively respond and refer (where appropriate) people in danger of domestic abuse:	*DA*	6.6	6.4	0.548	1.195	0.59
	1 = strongly disagree, 7 = strongly agree	*SI*	6.3	6.4	-0.245	1.703	0.809
Q8	Overall, I think that for me, effectively respond and refer (where appropriate) people in danger of domestic abuse would be:	DA	6.6	6.6	-0.326	0.669	0.748
	1 = Useless, 7 = Useful	SI	6.6	6.7	-0.196	1.065	0.847
Q9	Most people who are important to me in my profession effectively respond and refer (where appropriate) people in danger of domestic abuse:	DA	5.5	6.1	-3.081	0.921	**0.006**
	1 = strongly disagree, 7 = strongly agree	SI	5.7	6.2	-2.206	0.945	**0.038**
Q10	It is acceptable to effectively respond and refer (where appropriate) people in danger of domestic abuse:	DA	6.4	6.5	-0.288	1.513	0.776
	1 = strongly disagree, 7 = strongly agree	SI	6.5	6.5	0	1.243	1.00
Q11	I have the ability to effectively respond and refer (where appropriate) people in danger of domestic abuse:	DA	4.7	5.9	-2.891	1.887	**0.009**
	1 = strongly disagree, 7 = strongly agree	SI	5.1	6	-2.201	1.800	**0.039**
Q12	Overall, I think that for me effectively referring/responding to (where appropriate) people in danger of domestic abuse would be:	DA	6.4	6.7	-2.092	0.730	**0.049**
	1 = Harmful, 7 = Beneficial	SI	6.5	6.7	-1.283	0.650	0.213

Both before and after the training, staff reported high levels of good intent (Qs 1,4,7,8,) to support people with both DA & SI. They agreed that effective response or referral by pharmacy staff is both acceptable (Q10) and beneficial (Q12). Compared to before the training, afterwards staff showed statistically significant improvements in their levels of perceived ability, ease and confidence in responding to and referring people in need of help for SI & DA (Q3, 5). Their opinion of the ability of other pharmacy staff to support DA (Q2,6,9) & SI seemed to increase (Q2,9). Overall, the mean scores obtained were all at or above the mid-point for each response scale and show a preparedness and perceived capability towards responding and referring for both issues.

Intervention Results - The service was successfully implemented into the intervention pharmacies in partnership with senior staff in the pharmacy organisation and with the support of the referral organisations.

The staff participants (Lifeguards) consistently fed back at all monthly site visits that they felt more confident and empowered to initiate conversations with customers and identify signs of DA/SI. They approached many clients whom they encountered through the normal course of their care, who appeared to be showing signs that could indicate they were experiencing DA and/or SI. In contrast, only two clients initiated conversations about the Lifeguard Pharmacy with

pharmacy staff. Staff reported that they found it cumbersome and contrary to the flow of normal pharmacy activities to ask clients for written consent for the research study, particularly because they may not know the reason for a person's distress at the point at which they approached them, and therefore they could not determine whether the client met the eligibility criteria of experiencing suicidal ideation and/or domestic abuse. This limited the ability of the staff to formally recruit the clients as study participants.

A total of four client participants were fully consented for the research study and the full set of data was collected from them. Since the staff had also been recruited as participants it was possible to collect data on their experiences of using what they learned from their training and their use of the resources in the staff focus groups and field notes from the site visits. Staff found interactions with clients about SI or DA highly memorable and they valued being able to debrief on their experiences in the focus groups. Through this combined data, it was possible to collate basic information for a further 20 cases, and more general feedback on 33 interactions for other issues.

Table 4
Details of client cases

	Number of cases collated from staff reports	Number of cases with complete data set	Total number of cases
SI – Level 1 - Assistance	3	0	3
SI – Level 2-Action	4	0	4
SI – Level 3 -Alert	0	0	0
SI – category not known	1	0	1
Total SI	**8 (40%)** Male x 3, female x 4, not known x 1	0 N/A	**8 (33.3%)** Male x 3, female x 4, not known x 1
DA: Level 1-Assistance	1	1	2
DA :Level 2 -Action	2	1	3
DA: Level 3 -Alert	1	0	1
DA – category not known	3	0	3
Total DA	**7 (35%)** All female	**2 (50%)** All female	**9 (31.5%)** All female
Both SI and DA: Level 1-Assistance	1	1	2
Both SI and DA: Level 2-Action	1	1	2
Both SI and DA: Level 3- Alert	0	0	0
Both SI and DA – category not known	3	0	3
Total for both SI and DA	**5 (25%)** All female	**2 (50%)** All female	**7 (29.1%)** All female
TOTAL	**20** Male x 3, female x 16, not known x 1	**4** All female and white British Ages: 25–34 years old x 1, 55–64 years old x 2, over 65 x 1.	**24** Male x 3, female x 20, not known x 1

Results from total cases – Eight cases were for suicidal ideation, nine for domestic abuse and seven were for both domestic abuse and suicidal ideation (see Table 4). Cases were generally at the action or assistance levels (37.5% and 25%, respectively), with only one case (4.2%) at the highest level of alert. It was not possible to determine the level of severity/urgency from the data for seven of the cases. Most clients were female (83.3%). 25% of all cases were known to involve drugs and/or alcohol issues.

Of the 24 cases, 22 were staff-initiated and two were client-initiated interactions. The cue card was used by one client to initiate a request for a consultation, and this was a female DA case. Eight clients (24%) returned to the pharmacy to speak to staff on at least one occasion after their initial consultation. The high levels of staff-initiated consultations, together with high numbers of returning clients, suggests that pharmacy staff had good relationships with the customers and developed trust and rapport (as further outlined in the staff focus group results). From the field notes, one case was described where a female DA and SI combined client was successfully assisted and now returns every week just to say hello to the staff and to thank staff for their assistance. There were similar staff reports of clients sending e-mails or returning to say thank you.

Staff reports of the services that were referred to across all the cases were: GP, Mental Health Crisis Team, Domestic Abuse services, the Police, other mental health services, sexual violence services, the mental health crisis café (volunteer run), bereavement support charities and other local community support

organisations.

Results from the four full dataset cases - One consultation was client-initiated and the other three were staff-initiated. One consultation was conducted by a pharmacist, one by a technician and the other two were conducted by dispensers. Two of the consultations took 15–30 minutes, one took 30–60 minutes, and a time period was not recorded for the other consultation.

All four clients reported that their visit was opportunistic rather than being planned and the stated reasons for using a pharmacy service were: familiarity with staff, rapport with staff, it being a walk-in no appointment service, it being a familiar environment, and it being an in-person service. All agreed to give their personal details. In terms of a future study and whether they would hypothetically be willing to be followed up, one participant said she would definitely be unwilling and three were unsure.

DA was involved in all of these four cases, but none of these clients had previously accessed any DA services in the last 3 months. One had accessed mental health services and one had accessed the drugs and alcohol service. Referrals from these four cases were made to domestic abuse services (n = 2), GP (n = 2), drugs and alcohol service (n = 1), the crisis team (n = 1) and other charity support services (n = 2). One of the clients was referred to a total of four relevant services. This shows the breadth of services that the staff participants were able to refer clients to, and the tailoring of referrals to the client's individual needs.

Results from other customer interactions - Staff reported using their Lifeguard training in at least 33 additional instances in lower-level or one step-removed cases, and they had given clients support cards. Two were for relatives of people experiencing suicidal ideation, two for general distress, two for clients who were upset about their medication, 3 for bereavement (which sometimes included bereavement by suicide), three for financial concerns and 21 for other mental health issues. All pharmacies reported use of their Lifeguard training in these types of client interactions.

Control pharmacies - There were two reports of cases in control pharmacies. These occurred in the same pharmacy. One was for domestic abuse and the other was for suicidal ideation. The staff member involved had originally been trained while working at an intervention pharmacy but then had moved to a control pharmacy, so this is activity may be due to contamination. However, this adds further evidence for the effectiveness of the training on motivating and enabling staff to identify cases.

Staff support - Sessions with a psychotherapist were made available for staff in case they wished to debrief about any client consultations. These were optional and confidential. Three staff participants had one support meeting and one had two meetings.

Nested Process Evaluation

Staff focus groups

In total, 27 Lifeguards participated (22 women and 5 men), with representation from all eight intervention pharmacies attending a focus group. Analysis identified four main overarching categories of themes of Setting, Impact, Staff Experience and Improvements with 14 sub-themes as shown in Fig. 2.

For the purposes of this analysis a distinction is made between "customers" who are the people generally using pharmacy services and the "clients" who are the people that the Lifeguards specifically used Lifeguard resources and had consultations with. A further distinction is made between "cases" which were cases of clients that met the study criteria of experiencing either DA and/or SI and "interactions" which were Lifeguards used their learning, skills and Lifeguard support materials for other issues.

Theme 1: Impact - Participants described at length the perceived impact that the service had had on them and their clients, giving outlines of cases that they had had.

Overall value of the service - All participants agreed that the service was of overall benefit. They had applied their Lifeguard training to their interactions with customers and found the Lifeguard resources invaluable in giving them a supportive structure to delve deeper and enquire about possible SI and/or DA in those interactions.

....and his [client's] demeanour changed, so I did the same and sort of probed a little further, until basically, asking the right question and him saying "I'm getting the last few things in order and then I want to do it." [referring to taking his life] So, it escalated really quickly, over the space of about five minutes. And then, obviously that changed the conversation and we set up a few different things in place.

(staff participant - online FG, group 1, 25/04/23)

Connections made through these interactions often built over time, with customers returning to continue conversations.

I've had one person myself that has actually come back twice to me. First time, it was for suicidal ideation, and the second time it was for domestic abuse. So, because, the first time we met, we made such a good impression and we've been touching base, because it's a village setting and it was, sort of, a case of she'd become familiar and safe with us, she then felt open enough to come and speak about something else she was concerned about and we could help her further.

(staff participant - online FG, group 2, 2/05/23)

Relationship with Customers – Staff often had very good relationships with their customers, they had many "regulars" that they knew well. This facilitated identification of signs of distress if somebody looked "slightly off". Staff reported seeing clearly what had previously been hiding in plain sight. For example, realising that a woman, whose daily methadone supplies were often collected by her partner, was not receiving them and was experiencing domestic abuse.

Several staff reported that having Lifeguard consultations with their customers who were already “regulars” created a bond and improved their relationship with them.

…it made a bond that we didn’t expect as such. It’s stronger somehow…

Yeah, there’s no question about it, the clinician-patient relationship jumps a level if you have that interaction….

(discussion between two staff participants in in-person FG, 17/04/23)

Overcoming access barriers – Staff spoke about the perceived barriers that clients face in asking for help, such as fear of prejudice and judgement from others and the client’s own experiences of shame or pride about asking for help.

“ *I think it is so difficult for people to ask for help in the first place. If they’ve been to their GP and they get knocked back, if there’s nobody there to fill that little gap and fight for them, they’re not going to get the help they need*”.

(staff participant, online FG2 25/4/23).

Even when a connection had been made there could be a further reluctance to being referred due to fear and possible repercussions such as social services becoming involved. This was particularly apparent for some clients experiencing DA who often had their partner waiting outside. One participant reported how he and a fellow Lifeguard had used a pincer approach to deliberately delay the dispensing of a client’s prescription to give the Lifeguard an opportunity to talk to the client. Staff found the QR code client support cards invaluable in these reluctant or hurried type situations.

Substance Use Disorder – A particular group of customers that featured extensively in the focus group discussions were people who were being treated for substance use disorder. It was notable that staff often had a particularly good relationship with these clients and that they recognised that these customers had often had incredibly difficult lives and needed extra attention.

A few of ours have been some of our “blue scripts”, which are addict scripts that we've gone in to give them that dose in a private room….Because they’re people we see day in, day out, you know when something is not right. We tend to be, sort of, “Are you okay? Is there something wrong? You don't seem yourself today.” That's where the conversation tends to start.

(staff participant, online FG, group 2, 25/04/23)

Theme 2: Setting - Staff considered community pharmacy to be a suitable setting if there was local need, flexibility around the scope of the service and sufficient capacity to deliver the service effectively.

Community Pharmacy Setting – Being drop-in, easily accessible and a neutral environment were considered to be facilitators for help-seeking behaviour.

… the perfect place. Because you can walk into a pharmacy and it’s not suspicious

(staff participant, in-person FG, 17/04/23)

A key enabler was not only that customers could “drop-in”, but that they could also “drop-out”, in that they could leave when they wanted. Many clients were in a hurry or had somebody waiting but were able to have snatched conversations that may not have been possible in an appointment-based service.

Most cases were identified opportunistically whilst doing another service or were connected to issues with medicines. Having good links with local GP practices was advantageous.

And as soon as I knew that he wasn’t taking his meds, that’s where I probably changed my questioning style […] when he said he wasn’t taking his meds, that is automatically like a red flag for me that there’s always, usually, a reason for it

(staff participant, online FG, group 1, 25/04/23)

Local need – Some pharmacies had requested to be intervention pharmacies because they perceived there to be a local need due to encounters with previous cases of SI. In rural areas, pharmacy services were considered to be more essential because of a lack of other services. However, a counter consideration was the concern that clients may not ask for help from the staff who themselves lived in the small community.

I’d hope it would continue and spread a lot further, because I think it's invaluable. It should be shouted from the rooftops, in my opinion, especially for the rural places who've been in desperate need of mental health because the only place they've got to go to is the GPs. A lot of the time, they don't have time to see them…

(staff participant, online FG, group 2, 2/05/23)

Scope - Participants described that community pharmacy interactions were completely unfiltered, unpredictable and difficult to fit into neat diagnosable categories. This made it challenging to identify if clients met the study eligibility criteria. Some of the challenges around identifying suicidality were discussions around clients who had been suicidal in the past but were not actively suicidal now, clients who had significant risk factors but were not actively suicidal now and clients who expressed passive suicidality.

One sort of older chap come in who struggles with mental health anyway…He wasn't actively suicidal at the time, but he did say that he has thought in the past about hanging himself. So, we gave him… in fact, I had already given him the numbers off the green card before that because he'd already been in when he wasn't particularly bad, but I knew he was a bit lonely.

(staff participant, online FG, group 1, 25/04/23)

Similarly, there were discussions around what counts as domestic abuse, for example does it include abuse from carers, or from gang members.

Capacity – The Lifeguard service increased the responsibilities on staff, but also increased their capacity as individuals and a team to handle difficult conversations.

The consensus around the length of time needed for a Lifeguard consultation was a minimum of 15 minutes, but ideally 20 to 30 minutes. It was considered that if you have the correct staffing levels, 30 minutes should be possible. The Lifeguard service was seen as a priority over other services, which needed time to conduct a consultation satisfactorily.

I'd rather it take longer and the patient feels happy and then be improved and it take 45 mins rather than them be 15 minutes and them not feel any better. I'd rather take 45 minutes and not get (another) job done.

(staff participant, online FG, group 2, 2/05/23)

Working in a strong team was seen as important so that others would pick up tasks whilst the Lifeguard colleague was in a consultation.

Although conducting Lifeguard consultations placed extra time burdens on staff, it was recognised that these encounters can happen anyway. If there is a structured process, such as Lifeguard, in place, then it may actually save time and reduce stress, because they know how to respond, and it allowed pharmacists to delegate to others.

And so, whereas I would always deal with these myself (as a pharmacist), I now turn to another Lifeguard and go, actually, I need you to deal with this. And you can tell they straighten as if to say, right, time to do something good…. it gives me the confidence and it gives me a mental health sub team.

(staff participant, in-person FG, 17/04/23)

Theme 3: Staff Experience - Staff were empowered and felt a sense of duty and pride in being a Lifeguard, but there was a risk of negative emotional impact.

Staff empowerment – staff felt enabled to identify and intervene in suspected cases of SI and/or DA. Having clear referral/signposting pathways, support cards and QR code cards increased confidence and ability because staff now had the tools to refer and support clients.

I'm much more confident because I do have the facility to signpost people to the correct places they need to be. Also, if I'm not sure, there's all the list of places they can go. I can pass that on to them. Then, if they don't want you to do it themselves, they've got this card where they can take it away, look at it, and then decide what they want to do, rather than an on-the-spot decision

(staff participant, online FG, group 2, 25/04/23)

Emotional impact – Concerns were expressed about the service blurring into counselling and being a crutch for people, with fears of it being emotionally draining and time consuming. It was also noted that DA and SI conversations could be triggering for staff.

Being a Lifeguard – It was evident in the way participants spoke that being a Lifeguard had a clear identity, that came with a definite sense of duty, a sense of satisfaction for helping people and also feeling proud of those achievements.

I would say that it felt like you had a bit of a title, and you feel like, "I've got my own arm bands on and being a lifeguard myself….(laughs). Puts a lot of pressure on your shoulders, that, "I'm a lifeguard.

(staff participant, group 1, 2/05/23)

The key success of the project was seen as being that it has left a legacy of trained and empowered staff.

"*A lot of people have had well-intentioned schemes that are a dead end, and I think if I made a difference here for me that sets this apart, it's that you haven't made a scheme as such. You've made people.*"

(staff participant, in-person FG, 17/04/23)

Theme 4: Improvements - Suggestions were made for improvements to the paperwork and marketing. Staff were keen that the service should continue and be implemented more widely, and they made recommendations for improvements.

Paperwork – Staff participants all reported that they found the paperwork associated with consenting client participants overwhelming and burdensome. There were only 4 consented client participants in which staff were able to collect the full set of data. Reasons for the difficulties obtaining consent, were firstly that most cases were staff initiated and it seemed awkward and that it would disrupt the flow of a sensitive conversation to ask for consent during a conversation that had arisen opportunistically.

I can't even visualize myself at all having a conversation, a deep conversation with somebody and then saying ohh, then just get some paperwork out and asking them to complete it then.

(staff participant, online FG, group 2, 25/04/23).

Secondly, staff reported that some clients were reluctant to complete paperwork because it made it more formal, and the volume and language of the participant information sheets and consent forms was off-putting for staff and clients alike. It was noted that pharmacy staff are not used to obtaining written consent for any services and that interactions occur in a fast-paced responsive manner. Some staff said that they just forgot to ask.

Marketing – Staff participants stated that the Lifeguard Pharmacy name meant something to them, but they thought the service had not been sufficiently advertised to the public, and that the marketing was too discreet. They thought that this may account for the lack of client-initiated cases.

Recommendations – Staff suggested ideas to increase access to the service, which included having referrals into Lifeguard Pharmacy from other organisations, and having an app that clients could use to make an appointment for a Lifeguard consultation. It was noted that the time of a first prescription for mental health medication is a critical time for patients. This would be a valuable time for Lifeguards to offer support and screen for risk of harm from SI and/or DA.

Feasibility workshop

The workshop was held in June 2023 with 42 participants, which included 14 Lifeguards from 6 of the 8 intervention pharmacies, 11 members of the research team, 7 co-investigators, 6 members of the Public and Patient Involvement (PPI) panel, 2 senior members of staff from the pharmacy organisation and 3 representatives from local mental health organisations (NHS and charity). Because 2 out of the 8 intervention pharmacies were not represented at the event, it was repeated as an online alternative in August 2023. Two Lifeguards from one pharmacy attended this event plus the two research facilitators (JS and AB). This meant that one pharmacy was not represented, but they had already given feedback at the monthly site visits.

Topic 1: Scope - Overall, participants thought that it made sense to include both suicidal ideation and domestic abuse in the service (n = 37, 94.9%), as the issues often overlap, and are encountered in pharmacies on a regular basis. Interestingly, the large majority believed that the service should be extended to include other mental health difficulties (n = 31, 79.5%) since various clients need this support and it could be more widely accessible in communities. In addition, most participants were also in favour of extending it for drugs and alcohol support (n = 21, 53.9%), sexual assault support (n = 24, 61.5%) and common social problems (e.g., debt, bereavement, n = 23, 59.0%). These issues were perceived as interconnected with mental health issues and commonly seen in pharmacies. The following quote illustrates the perception of a Lifeguard about the types of issues that should be included in the service: *"Our pharmacy encounters all of these issues on a regular basis so would be difficult to decide what should be included or dismissed"* (Participant 33, Lifeguard).

Topic 2: Setting - The pharmacy setting was considered suitable for this service (n = 38, 97.4%, Fig. 2). Pharmacies' high accessibility, safety and friendly staff were pointed out as the main benefits. Most participants also believed that the Lifeguard Pharmacy could be a national service available in all pharmacies that choose to participate (n = 27, 69.2%), but particularly in pharmacies that meet certain quality criteria, such as having enough trained Lifeguards (n = 30, 76.9%), staffing levels and a supportive organisational culture. Having concerns about the quality of the pharmacies that would be eligible to run the service in the future, participant 18 (researcher) said the following: *"Pharmacy staff must be motivated, committed and supportive of each other. Organisational culture must be right. Not all locations will be suitable."*

In relation to the method of delivery of the Lifeguard training, the in-person method was strongly preferred (n = 30, 76.9%) in comparison to facilitator-led online with (n = 13, 33.3%) or without a facilitator (n = 1, 2.6%). The greater similarity with reality, available in the in-person training, was seen as helpful for learning the key skills required to be a Lifeguard. In person, Lifeguards had mock consultations like the ones they would encounter in real life, and they had the opportunity to practise their social, empathy and communication skills while facing another individual. Besides this 'real-life' aspect, the in-person training was also perceived as more interactive and fun, increasing participants' learning. However, the online method was still considered indispensable by various participants, due to it being more accessible and therefore not excluding those who could not attend in-person training.

Where possible I think [in-person training] is better, but my training was issued over 3 sessions via teams/zoom meetings and I feel I learned what I needed to. I would have ideally liked to have had in person training.

(Participant 38, Lifeguard)

Finally, when asked about the type of staff that should be accepted to deliver the service, they were in favour of a more inclusive approach where all patient-facing staff roles are accepted (n = 29, 74.4%), and a minority of them thought it was important that at least one of the Lifeguards in each pharmacy is a permanent pharmacist (n = 10, 25.6%). Various participants emphasised that there are other characteristics more important than the job role of the candidate, such as taking part in the training and being motivated to help others, and being empathic and approachable. The following quote illustrates this: *"Lifeguards should be chosen based on characteristics [other than job role] and why someone wants to be a Lifeguard." (Participant 2, insight panel member).*

Topic 2: Client access - Overall, participants were against a staff-initiated type of service only (n = 32, 82.1%), and they believed that a client-initiated service was possible in the right conditions (n = 35, 89.7%). Both client- and staff-initiated options were preferred, as some participants were concerned that a service limited to staff-initiation would lead to selection bias and cases being missed. Another concern was that some clients might not want to be approached but, in a staff-initiated service only, staff would be under pressure to approach individuals: *"Of 17 cases, 16 have been staff-initiated. However, staff do not always know what is going on, and the client option is important."* (Participant 27, stakeholder).

One participant mentioned that a service limited to staff initiation was positive due to its uniqueness of being a proactive service, whereas pharmacy team members are already used to responding to clients' requests.

Most participants thought that the name Lifeguard Pharmacy should be kept but that the marketing should be more explicit (n = 26, 66.7%) and that "safe space" should be added to the marketing (n = 24, 61.5%). Participants were strongly opposed to a more discreet marketing (n = 31, 79.5%): *"I think the marketing needs to be explicit in order for people to have a good idea of what the service is for."* (Participant 23, stakeholder).

Topic 4: Record keeping - Views on whether it was possible to obtain written consent from clients was mixed, many participants were unsure (n = 14, 35.9%). However, the majority believed that it was not necessary to obtain this type of consent if the Lifeguard Pharmacy became a standard service (n = 25, 64.1%). Getting written consent was perceived as a difficult task, particularly as it could be inappropriate and disruptive when dealing with a customer in need of help. Interestingly, various participants suggested that verbal consent should be used instead, as it is more straightforward, empathic and informal. *"Consent and demographics data gathering is a significant barrier to deliver the service."* (Participant 34, Lifeguard, referring to written consent).

There was no clear agreement about the preferred method of data collection during the consultation. However, the use of a tablet computer was supported by various participants (n = 16, 41.0%), whereas many were opposed to the use of paper (n = 15, 38.5%) or desktop computer (n = 17, 43.6%).

Views were also mixed about the possibility of obtaining additional data from clients. A few participants thought that they could obtain additional data on demographics (n = 15, 38.5%), but various of them were opposed to this (n = 10, 25.6%), and many were unsure whether it was possible to obtain additional data on views and preferences from clients (n = 15, 38.5%)

Finally, many participants were unsure whether it was possible (n = 23, 59.0%) or advisable (n = 18, 46.2%) to follow-up clients to see how they had progressed.

Summary of findings

With appropriate training, a consultation guide, referral systems and client support resources it is feasible for pharmacy staff to identify, intervene and signpost or refer clients experiencing a range of levels of suicidal ideation and/or domestic abuse to appropriate support organisations in a timely manner. A range of pharmacy staff (pharmacists, technicians, dispensers and counter assistants) from the intervention pharmacies were trained as Lifeguards. They applied their learning and used the intervention resources in cases of suicidal ideation, domestic abuse and both issues combined. Most interactions were staff initiated and occurred opportunistically.

Community pharmacy setting

Community pharmacy was considered an ideal setting for an SI/DA response service because customers can enter and leave at will and because it is a neutral generic environment. There are good relationships between staff and customers and there is connection to medicines and other healthcare services.

Staff experience

During a time where community pharmacy capacity in England was particularly stretched (30), staff were willing to support people with DA and/or SI. They recognised a need for more formal support in pharmacy, as exemplified by the pharmacy that requested to be in the intervention arm. The Lifeguard training programme increased confidence in response and referral, and Lifeguards also used the tools to support people with other presenting problems. There are parallels with the Bloom programme in Canada (31) and AMPLIPHY study in England (32), which described how consultations about mental health medication often resulted in wider discussions that were unrelated to medication and the disclosure of other problematic life experiences (e.g. bereavement, abuse).

Lifeguards embraced the role with a sense of duty, satisfaction, and pride. They reported that they had good relationships with their regular customers and that “Lifeguard” consultations further strengthened them. There was a clear sense of the whole team effort, with the non-Lifeguard staff facilitating Lifeguards to have consultations through recognising when a staff-initiated consultation may be needed and adjusting workload to accommodate it. Approximately 30 minutes per consultation was recommended, with more time being needed in crises. This ‘trickle down’ effect, with Lifeguards as ‘champions’ has parallels with other schemes, such as Healthy Living Champions (33). Being a ‘Lifeguard Pharmacy’ may have positively affected the organisational culture of specific pharmacies, although it is recognised that the pharmacies nominated by the pharmacy chain management may have been untypical. Trusting relationships between staff and management, and prioritisation of improvement, including commitment to change, have been shown to improve community pharmacy practice (34).

Facilitating referral and signposting

Access to appropriate referral resources, both to recommend to clients and provide directly (via QR codes) were perceived as beneficial. The need for well-defined referral pathways to support people with suicide prevention has previously been suggested in England (35). Understanding local provision was similarly essential in AMPLIPHY and added to staff confidence in potentially challenging conversations (32).

Strengths of the study

The Lifeguard service worked well as a staff-initiated response service. It provided supportive structure that motivated and enabled pharmacy staff to opportunistically identify people experiencing SI and/or DA during their normal pharmacy activities. Strengths of the service include: the focus on both SI and/or DA; the comprehensive package of service resources that were created through co-development with people with lived experience; the optional and confidential debrief facility with a psychotherapist for emotional support and the additional pharmacy specification criteria that ensure that the service is conducted safely for both clients and staff.

A strength of the study design was the use of a nested process evaluation alongside the intervention. In particular, the staff focus groups produced a rich data set that provided an understanding of the benefits and the limitations of the service.

Limitations of the study

The study was a feasibility trial, involving 12 community pharmacies owned by a single pharmacy chain and within one English county. Further evidence from a wider range of settings is needed to establish the delivery potential and effectiveness of this intervention.

The CPD reaction questionnaire was adapted for the purpose of this study and so no prior sample size calculation could be undertaken. It is therefore possible that some null effects on the before and after training question items may be due to lack of statistical power. Furthermore, 24 statistical comparisons were undertaken, and no adjustment was made for multiplicity. However, 11 of the 24 comparisons showed a statistically significant improvement in ratings after the training, with none of the comparisons showing an effect in the opposite direction.

Identified challenges and limitations to implementing Lifeguard Pharmacy

There are distinct challenges to implementing Lifeguard as a pharmacy service and as a feasibility trial.

a) Lifeguard as a service in pharmacy

Concerns were expressed that members of the public may be reluctant to approach for help in busy pharmacy environments or provide details for fear of unwanted referral. Given that it takes tremendous courage for a person to ask for assistance it could be harmful if there were insufficient staff on duty to attend to the person. It is vital to ensure an ongoing provision of sufficient numbers of adequately trained staff to absorb flux in staff changes and working hours, thus ensuring that there is capacity to deliver the service effectively. There are risks to both client and staff wellbeing if standards are compromised. In addition, staff delivering the intervention need to have access to independent, confidential emotional and debriefing support. This study provides evidence for the feasibility of a staff-initiated response service, but not at this stage, for a service that is advertised directly to the public as a client-initiated service.

Building and maintaining of relationships with external stakeholders is key to expanding the study. Quality of service could be managed through an independent accreditation role, external to the pharmacy organisation. This would ensure intervention fidelity, quality standards and appropriate staff support.

b) Lifeguard as a feasibility trial

Staff encountered barriers in recruiting these clients to the study, because most conversations were staff-initiated in an opportunistic manner, rather than being client-initiated. Therefore, it seemed disruptive to discuss the study with clients and the paperwork was onerous. This seemed to relate to consent to the research study rather than client willingness to receive help from, what to them, may have presented as a usual pharmacy service. Similar challenges in recruitment to a community pharmacy trial for brief psychological intervention for depression were found in the CHEMIST study in the North-East of England (36). Verbal consent would better align with consent for other community pharmacy services (37). Additionally, verbal consent has been utilised in previous studies where it has been recognised that signed consent form use can be intrusive and unnecessary (38). It was difficult to randomise pharmacies, or to recruit pharmacy staff prior to randomisation. In addition, due to the geographical location of the study there was a lack of ethnic diversity in the staff participants, affecting the generalisability of these findings.

Implications for research and practice

Staff participants and stakeholders hoped that the service would continue. They could envisage national roll-out to pharmacies that have been accredited as having suitable quality criteria, numbers of trained staff, specified staffing levels and a supportive organisational culture. It was recognised that people in various patient-facing roles, not restricted to registered pharmacy professionals, could be Lifeguards.

Stakeholders endorsed inclusion of SI and DA, with client presentations confirming the assumed overlap of the two issues, but also considered an expansion to support people with other mental health conditions. Some of the identified clients were receiving drug and alcohol support from pharmacies and were recognised as a client group that could, and did, benefit from additional support. Interventions could be targeted to people first prescribed a mental health medication. This would align with the ambitions of the New Medicines Service in England, which is expected to be expanded to include antidepressants (32, 39) and has been long called for (40).

The original design of this intervention was as a client-initiated service that lowered barriers to access for people seeking help, but most contacts were staff-initiated. Whilst there was support for the service to continue in both guises, a client-initiated service would need to be supported by more explicit, but sensitive marketing consistent with relevant guidance and assurances about maintaining adequate levels of trained staff and quality standards (41, 42).

The implications for research are that a process of co-development is crucial for any developments from this study. There are challenges to conducting a randomised controlled trial in this area of practice. A larger implementation study would be beneficial with a larger sample size, greater variety of demographics and pharmacy organisations and with a longer-term intervention. Given the difficulties faced in this study with client recruitment and the collection of outcome data, careful thought would be needed to the feasibility of evaluation within a larger randomized control trial.

Gap in service provision (what this study adds)

There is currently no other suicidal ideation response service in UK pharmacies. The findings from this study lay foundations for the provision of a new service Evidence from several high-income countries has shown that pharmacies are places where staff encounter patients with suicidal thoughts and/or behaviours, and they want robust training and referral pathways to support their conversations(43–47). Through inclusion of the Zero Suicide Alliance training and associated action plan requirements in the 2020/21 PQS, a commitment to the role of pharmacy teams in England was made (24, 48). A similar commitment,

but lack of full process and procedure, exists for DA support in pharmacies in England. Pharmacies participate in the “Safe Spaces” and “Ask for ANI” schemes, which promote pharmacies as safe places where the use of the code name “ANI” can alert staff to the need for help (13). They involve staff offering the consultation room for people to call either the Police or the National Domestic Violence Helpline. Lifeguard offers expansion of this model through robust pharmacy-specific, facilitator-led training, with consultation and referral support materials for staff and patients, and with debrief and buddy support for staff.

Conclusions

There is currently no other SI response service in UK pharmacies and previous DA services have not provided the same level of training and support for staff. Lifeguards have developed skills in identifying those at risk and intervening early.

The study indicated that it is feasible to implement a predominantly staff-initiated response service for domestic abuse and/or suicidal Ideation, that is empowering for staff and could be of benefit to patients. To facilitate this, it would be essential to provide quality training and support to those staff selected to be Lifeguards within the pharmacy; to ensure adequate staffing levels and consultation room availability to enable staff to have the capacity to conduct Lifeguard consultations, and for specified quality criteria in the pharmacy to be met in order to ensure the safety both of patients and staff.

This study highlighted the potential for community pharmacies to respond to people in danger from DA and/or SI, with trained staff providing consultations and referral or signposting. There is the potential to reduce patient harm from DA and SI and in turn reduce costs to both the health system and wider society.

As discussed above, a larger implementation study would be beneficial with a larger sample size, greater variety of demographics and pharmacy organisations and with a longer-term intervention.

Abbreviations

DA Domestic Abuse

SI Suicidal Ideation

PQS Pharmacy Quality Scheme

IRAS Integrated Research Application System

Declarations

Ethics approval and consent to participate

This study was approved by the North West - Preston NHS Research Ethics Committee (REC number 22/NW/0016, protocol number 21011, IRAS project ID 309018) within the UK Health Research Authority Research Ethics Service. All staff participants gave writteninformed consent to be part of the study.

Trial registration- https://www.isrctn.com/ISRCTN95063724 (15/09/2022)

Protocol available at - https://www.isrctn.com/ISRCTN95063724 (15/09/2022).

Consent for publication

Not Applicable

Availability of data and materials

The datasets generated and/or analysed during the current study cannot be shared publicly due to the sensitive nature of the topic and the risk of identification of participants.

Competing interests

The authors declare that they have no competing interests

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Authors' contributions

JS was involved in conception, funding acquisition, design, data acquisition, analysis and interpretation, drafted and substantively revised the paper. AB was involved in project design, data acquisition, analysis and interpretation and drafting the paper. RB was involved in project design, data acquisition, analysis and interpretation, drafted and substantively revised the paper. HG was involved in project design, interpretation of data and drafting and substantively revising the paper. TLG was involved in design, data acquisition and interpretation and substantively revised the paper. PK and CH were involved in funding acquisition, design, interpretation of data and substantively revised the paper. DB was involved in funding acquisition, design and interpretation of data. ER

was involved in design, data acquisition and interpretation. GL was involved in funding acquisition, design and interpretation of data. MG was involved in funding acquisition, design, interpretation of data and revised the paper. All authors read and approved the final manuscript.

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Figures

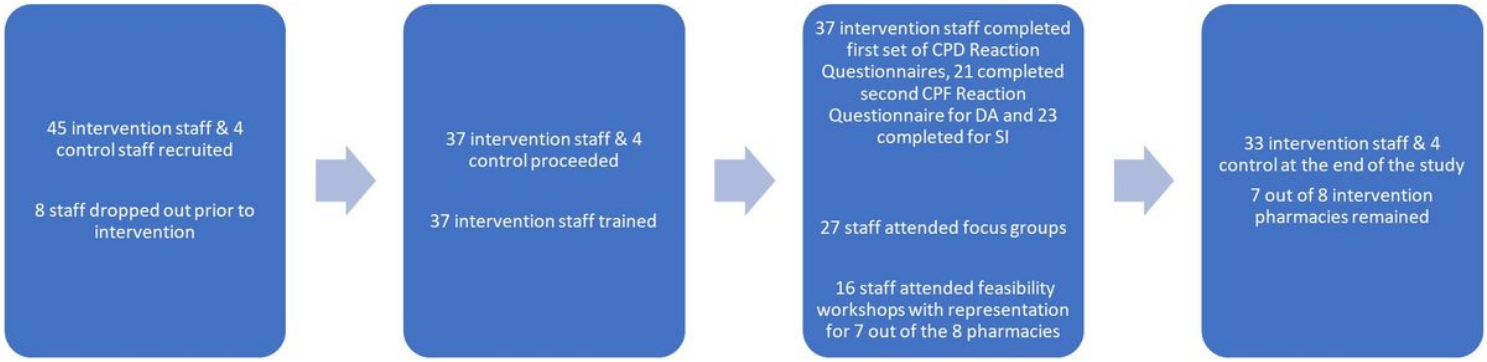
45 intervention staff & 4 control staff recruited
8 staff dropped out prior to intervention
37 intervention staff & 4 control proceeded
37 intervention staff trained
37 intervention staff completed first set of CPD Reaction Questionnaires, 21 completed second CPF Reaction Questionnaire for DA and 23 completed for SI
27 staff attended focus groups
16 staff attended feasibility workshops with representation for 7 out of the 8 pharmacies
33 intervention staff & 4 control at the end of the study
7 out of 8 intervention pharmacies remained

Figure 1

Flowchart of staff participant engagement throughout the study

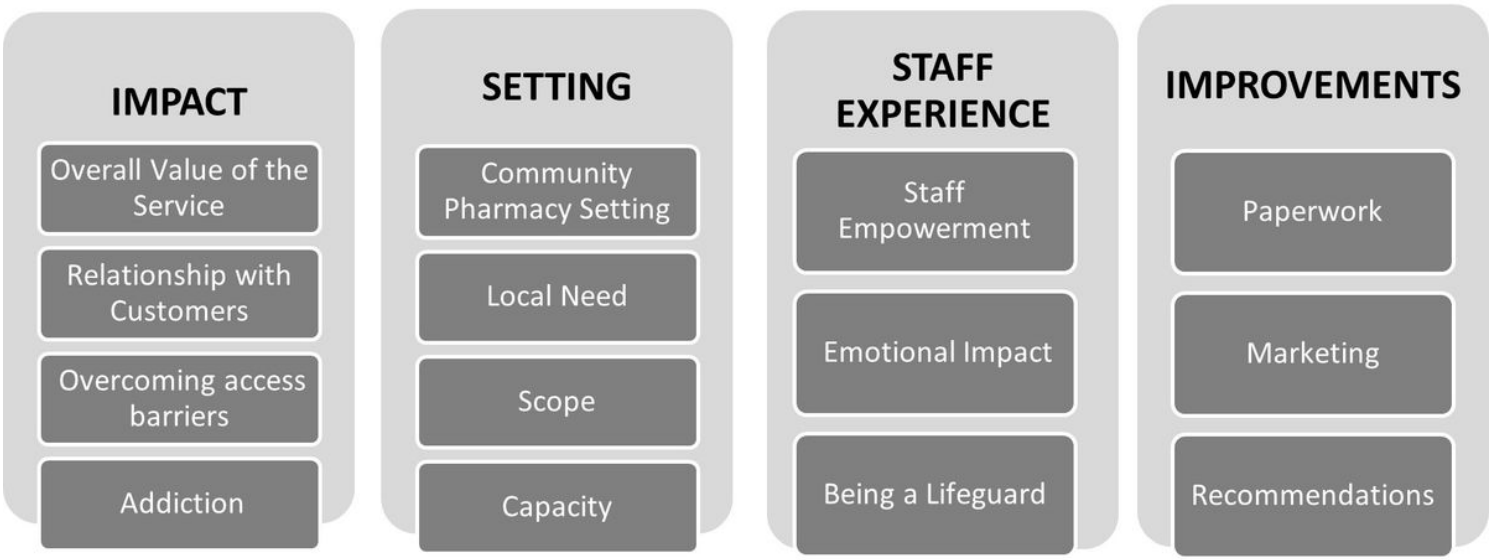

Figure 2

Staff Focus Group Themes and Sub-Themes

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- SupplementaryMaterialBMCPH11.03.2024.docx